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ABSTRACT

Crisis intervention programs for persons experiencing the sudden death of family members or surviving natural disasters have been advocated as methods of primary prevention, although few have actually been implemented. A program utilizing nurses to deliver grief intervention to parents losing a baby to Sudden Infant Death Syndrome (SIDS) was examined as an illustration of such preventive programing. This project covered the state of North Carolina and involved a sample of 154 subject families, after the infants' deaths, three home visits were conducted. Psychological goals of the visits were: (1) to reduce parents' guilt by countering inaccurate explanations for the death; (2) to encourage expression and acceptance of grief and to reassure them that this normal grieving process would end; and (3) to provide support in coping with problems. Demographic data on the families was similar to that reported elsewhere in that younger, unmarried, and nonwhite mothers were overrepresented. Because parents of SIDS victims experience profound feelings of guilt and especially severe crisis reactions, programs relieving guilt and providing additional support to them are felt to have significant preventive potential. Data tentatively supporting the conclusion that the SIDS grief intervention program had a beneficial impact on the participants. (Author/JLL)

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New Areas for Preventive Programing:

Sudden Infant Death Syndrome

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New Areas for Preventive Programing: Sudden Infant Death Syndrome

Prevention has long been a cornerstone of the community mental health movement and crisis intervention programs are among those proposed as viable avenues toward primary prevention (Caplan, 1964; Kessler & Albee, 1975; Zax & Cowen, 1976). Arguments will be made here for the preventive potential of a new and somewhat unique type of crisis intervention: grief intervention for the families of children dying from Sudden Infant Death Syndrome (SIDS). A program of education and counseling for SIDS families in North Carolina will be described and evaluative data will be reported suggesting that SIDS deaths produce especially severe guilt and grief reactions and that the resolution of these crises can be facilitated by brief interventions.

The term crisis intervention refers to several related and easily confused programs differing in their preventive potential. Emergency, short-term, or crisis intervention psychotherapy for individuals showing psychopathology or acute physiological distress is a relatively common application of crisis theory in community mental health practice (Aguilera & Messick, 1974; Caplan, 1964; Lindemann, 1944). Such programs have demonstrated therapeutic effectiveness (e.g. Langsley & Kaplan; Rosenthal & Levine, 1970). Except when families or children are involved, such programs have little primary prevention potential, however. Of the more preventive crisis intervention programs, two categories have been commonly recognized. These are programs for (a) persons experiencing acute stress from the death of loved ones or from natural disasters such as fires (Lindemann, 1944), earthquakes (Blaufarb & Levine, 1972), hurricanes (Richard, 1974), floods (Titchener, Kapp, & Winget, 1976), or tornadoes (Zarle, Hartsough, & Ottinger, 1974) or (b) persons in milder crisis states produced by developmental changes in themselves or members of their families (Dyer, 1963; Klein & Ross, 1965; Rapoport, 1963). Although the absence of adequate control subjects has made demonstrating the preventive impact of such programs exceedingly difficult, crisis theory, anecdotal evidence, and faith in the psychogenic hypothesis (Kessler & Albee, 1975) have continued to suggest that they can have preventive impact of a primary nature.

Most relevant to the SIDS interventions to be described are the crisis intervention programs for individuals grieving over the sudden death of a relative or close friend that have been reported. Notable are the Fort Logan grief intervention program (Polak, Egan, Vandenbergh, & Williams, 1975) and the Harvard bereavement study (Parkes & Brown, 1972). Participants in these grief intervention programs differ from those involved in disasters in that their crisis reactions are more circumscribed and limited to loss of an important person because they have not undergone extreme physical stress or had a brush with death themselves. This restriction in the crisis state under study is felt to be advantageous in that the cause of the disruptions in living is more circumscribed and less likely to be attributed to incorrect factors; in addition, restricted crisis states aid the evaluation of intervention programs by narrowing the range of variables which need to be included or ruled out.

The grief intervention program to be described deals with a further delimited crisis in that only one kind of death is involved and, as will be seen, the participants are relatively homogenous on demographic variables as well. Thus, the experience gained from this program of SIDS grief intervention should have implications for crisis theory and preventive programing in addition to reporting the application of crisis intervention techniques to a heretofore neglected population.

Grief Intervention for SIDS Families

Background Information

Sudden Infant Death Syndrome, or "crib death", is the sudden, unexpected death of an otherwise healthy infant between one week and one year of age (and with very low frequency after one year) occuring most commonly at three and four months. These deaths almost always occur while the child is asleep and subsequent post-mortem examinations reveal no usually accepted cause of death. SIDS is the leading cause of infant deaths between one week and one year of ge and accounts for 8,000 to 10,000 deaths annually in this country (Valdes-Dapena, 1970).

Although the cause is not known, the following are generally accepted as valid statements about SIDS. (a) Infant deaths fitting this pattern have apparently occured throughout history. A reference in the Bible (I Kings 3:19-20) to overlaying, or accidental suffocation by a parent sleeping with a child, is suggestive of SIDS. (b) SIDS does appear to constitute a distinct disease entity and not simply a category of unexplained infant deaths due to a variety of causes. (c) The rate of deaths from SIDS is two to three per 1,000 live births and this rate appears to remain relatively constant in different countries (Valdes-Dapena, 1967) and during periods of physical deprivation (such as world wars) when rates of other illnesses have been shown to rise. (d) A significant association has been found between lower weights at births and SIDS victims (Bergman, Ray, Pomeroy, Wahl, & Beckwith, 1972). (These statements are consistent with a constitutional or genetic etiology although the next two points suggest environmental influences are operating.) (e) SIDS is slightly more common during the winter months but occurs at any time of the year. (f) It also appears to be significantly related to socio-economic status (Bergman, et al., 1972), with the poor and less educated having higher rates (a corollary of this finding is the repeated observation that rates are also higher for Blacks and American Indians) (Valdes-Dapena, 1970).

Many erroneous explanations have been offered for SIDS deaths with the most common of these being accidental suffocation by parents or bed clothing. Research has explored and generally discounted a wide variety of causes including direct genetic transmission, infection, congenital abnormalities, and suffocation, although some investigators continue to study these possibilities. It is important to stress that a careful autopsy reveals no gross tissue abnormalities and that although some characteristic histological changes have been noted, research thus far has only eliminated some commonly offered hypotheses and suggested that a pattern of multiple causation is probable. An exciting but to date inconclusive area of current research explores the association between sleep apnea (temporary cessation of breathing) and SIDS (Steinschneider, 1972; 1977).

Etiological research on SIDS is difficult in part because there is no warning that a baby is about to die of SIDS and, thus, no way to identify potential casualties before they occur. Parents look in on their infant at night or during a nap and find them dead. Before SIDS was widely recognized by medical and law enforcement personnel, it was common for parents to be told their children died of suffocation or a quickly appearing form of pneumonia. Tragically, some parents have been accused of child abuse and actually incarcerated (Curran, 1972). Unfortunately, such inaccuracies and injustices still occur too commonly.[1]

There have been few discussions of the psychological impact of SIDS on families, "the survivors" as they are sometimes called (Cain, Note 1). Almost all have appeared in the general medical journals (Bergman, 1974; Bergman, Pomeroy, & Beckwith, 1969; Salk, 1971) although a few have appeared in psychiatric journals (e.g. Halpern, 1972). In fact, there have been articles in the literature about reactions to the death of children; among those found are papers on parents' reactions to infant death due to a variety of causes (e.g. Kennell, Slyter, & Klaus, 1970) and to the impact on children of a sibling's death (Cain, Fast, Erickson, 1964). Therefore, there is a need for descriptions of how SIDS grief reactions resemble other crises and of the effectiveness of attempts to intervene in such crises.

Federal legislation (P. L. 93-270) was passed in 1974 to support education and counseling programs for parents losing children to SIDS and 31 programs similar to the North Carolina project have been initiated in various regions of the United States since then. Thus, it is expected that more information on the impact of sudden infant death and on SIDS as an area for preventive programing will be forthcoming.

Program Description

Like 14 of the other 30 SIDS counseling and education programs, the North Carolina project covered an entire state. It consisted of three related components: (a) grief intervention for parents and other relatives, (b) educational workshops on SIDS for professionals and other community caretakers, and (c) an epidemiological investigation of SIDS etiology and the association between social supports and bereavement (Yauger, Note 2). Only the grief intervention will be discussed here. It began in July of 1975 and continued until October of 1976[2] and was administered by the North Carolina Office of the Chief Medical Examiner under a grant from the Department of Health, Education and Welfare. The Medical Examiner's Office in North Carolina was a logical agency to administer the grief intervention program since all sudden, unexplained deaths must, by law, be referred to that office where autopsies are performed to determine the cause of death. (Post-mortum examinations reveal evidence for causes of death other than SIDS in 15% to 20% of suspected SIDS deaths.)

The major goal of this program was to design a grief intervention program which could be delivered by nurses to SIDS families scattered over a large and typically rural geographic area. A prior study of county incidence data in North Carolina (Blok, 1978) suggested organized coverage of the entire state. Five experienced public health nurses living in different regions of the state were hired, three of them on a part-time basis. All were mature and had considerable experience (ranging from ten to twenty years) in varied clinical settings. They were given one week's

intensive training in psychological reactions to death, family crisis intervention techniques (such as (1) assessing what extended family members have been affected by the SIDS death and need to be included in the sessions, (2) identifying potential patterns of scapegoating or pockets of unexpressed emotion, and (3) facilitating open communication between the family members, communication about prior issues of contention in the family as well as about their grief), and use of the research questionnaire they were to administer to program participants. The nurses subsequently met at a central location for two days every six weeks for group sharing, supervision, and consultation. The author of this paper, a clinical psychologist, participated actively in their training and supervision. He also served as a telephone contact for emergency consultations.

The program was designed to maximize the number of potential SIDS families participating by actively seeking them out and to begin contact with them in the first few weeks after the babies' death. (Several SIDS parents indicated during the planning stage of the project that the first week or two following the deaths is a time of great activity and involvement with others; their recommendation to delay visits for two weeks was heeded.) Initial contact was made early, however, when a sympathy letter was sent to parents from the Medical Examiner's Office (usually within 24 hours of the autopsy) saying that their child may have died of SIDS and that autopsy findings would be forthcoming to confirm this. They were also sent a pamphlet about SIDS, told that a nurse would be calling on them within a few weeks, and invited to call collect to the Medical Examiner's Office for further information or clarification.

Three home visits were planned for all participants, once at 3 to 5 weeks, once at 7 to 9 weeks, and once at 4 to 6 months after the deaths. Because the home visits were arranged at the families' convenience and when fathers and siblings could be present if they wished, most visits occured in the late afternoons, the early evenings, and on weekends. Every effort was made to reduce unnecessary professional barriers between the nurses and the families, to maximize participation, and to facilitate trust and a non-judgemental, accepting atmosphere. For example, the nurses did not wear uniforms, encouraged family members to call them by their first names, accepted offers of refreshments, and tried to communicate their sympathy and concern for the family members' plight. This informality was especially important given the high proportion of SIDS families who were poor and of minority status, some of whom had understandable fears of officials inquiring into their baby's death.

The home visits were designed both to gather data for the epidemiological study and to intervene beneficially in the grieving process. Specifically, the nurses distributed literature about SIDS (some of it written on an elementary level), explained its contents, listened to the parents' stories, calmly accepted the parents' grief without becoming anxious or avoiding listening themselves, and administered the research tool. Although some professionals have objected initially to this combination of research and clinical objectives, it was the experience of the project staff that asking detailed research questions about somewhat sensitive topics (e.g., the parents' prepregnancy desire for the baby) facilitated the

counseling rather than detracted from it. To be sure, however, combining these two activities required skill and judgment. The nurses also offered continued support for the parents' efforts at coping with their lives without their child and facilitated referrals to mental health, social service, or vocational agencies when indicated. For some, this support involved continuing to listen to them talk of their sadness and frequent thoughts about the lost child and for others it dealt more with immediate problem solving (e.g. how to get food stamps) and the parents' concerns for the future, their decisions about whether to have subsequent children, to go back to school or work, or to seek special activities for their other children. Because the families' patterns of grieving and their individual needs varied greatly, the nature of the second and third home visits varied more than did the initial contacts.

There were three specific psychological goals for the grief intervention aspect of these visits: (a) to reduce the parents' guilt by trying to counter inaccurate explanations they were using to blame themselves or others for their baby's death, (b) to encourage them to express and accept their emotions of grief, whatever they might be, and to reassure them this normal process would eventually end, and (c) to support them in their process of coping with lingering guilt and sadness, others' false accusations, health and economic problems, or plans for the future.

Descriptive Data

Autopsies confirmed 202 SIDS deaths in North Carolina during the 15 months of the project. Nurses were unable to locate 33 families and 15 declined participation, leaving 154 or 76% of the potential families in the program. Reporting difficulties made complying with the proposed home visitation schedule difficult and only 58% of the 154 families were seen for the first time on schedule. Some of those seen off schedule were not reported until several months had passed since the deaths and most (67%) of the 15 refusing to participate came from this group. It was deemed unfortunate that so many were seen late, but the rate of participation was felt to be excellent as it was higher than those reported for the Fort Logan and Harvard studies (Polak et al., 1975; Parkes & Brown, 1972).

Table 1 presents demographic data on the families participating in the program. These data suggest the SIDS sample was more likely to be from lower social strata and Chi Square comparisons with 1970 North Carolina census data show that younger and non-white parents appear to be overrepresented. SIDS mothers were also compared to other mothers in the state and the results of these tests are presented in Table 2. White (but not non-white) mothers were younger and all SIDS mothers (a) had completed fewer years of formal education, (b) were more likely to have had their children out of wedlock, and (c) had fewer living children than North Carolina mothers having children during a similar time period.[3] The babies who died of SIDS were most commonly two to four months of age (much like those reported elsewhere) and 85% of them died in the first five months of life; the SIDS infants were also often the first child born to a couple (29%) and occasionally the last expected (10% had been sterilized following the birth of this child). Thus, the North Carolina SIDS sample was similar to those reported elsewhere (Bergman, et al., 1972) in that younger, unmarried, and non-white mothers were overrepresented.

Table 1

Demographic Characteristics of SIDS Families

Age	Mother %	Father %
13 - 19	39	12
20 - 24	38	44
25 - 29	19	26
30 - 34	4	18
	n = 154	n = 100

Education	Mother %	Father %
8	13	12
8 - 10	36	19
11 - 12	45	53
13	6	16
	n = 154	n = 99

Race	%
White	36
Black	56
Indian	7
Oriental	2
	n = 154

Marital Status	%
Single	29
Married	62
Separated	6
Divorced	4
	n = 154

Social status[a]	%
I	[illegible]
II	1
III	8
IV	24
V	65
	n = 148

Length of marriage	%
Less than 1 year	16
1 - 2 years	34
3 - 4 years	19
5 - 6 years	20
7 + years	12
	n = 101

[a]Based on education and occupation (Hollingshead & Redlich, 1958)

Table 2

Comparison Between White and Non-White Mothers and N. C. Mothers on Age, Education, Marital Status, and Parity

Race	Variable	N.C. (1969-1973)	SIDS sample	X^2 p<
White	Age			.001
	<18	7	20	
	18-35+	93	80	
	Education			.001
	<9	7	11	
	9-11	28	53	
	12+	65	36	
	Out of Wedlock Birth			.001
	yes	4	16	
	no	96	84	
	Parity			.003
	1	41	67	
	2+	59	33	
Non-White	Age			.23
	<18	17	12	
	18-35+	83	88	
	Education			.001
	<9	11	15	
	9-11	42	57	
	12+	47	28	
	Out of Wedlock Birth			.002
	yes	36	50	
	no	64	50	
	Parity			.003
	1	38.3	49	
	2-3	37.3	44	
	4+	24.3	7	

Note: North Carolina Maternal characteristics from Resident Live Births, 1969-1973.

Evaluative Data

Anecdotal reports (Bergman, et al., 1969; Halpern, 1972) have suggested that higher than what they felt were average rates of marital discord and mental health contact were found in this group following the babies' deaths. Although 154 cases is too small a number to make reliable comparisons with known rates of such events in larger populations, this expectancy did not appear to have been borne out. For example, no marital separations were observed in marriages in which serious problems were not reported to have been present before the baby died and no psychiatric hospitalizations of SIDS parents occured during the six months of contact. (One grandmother was hospitalized following a SIDS death, however.) The absences of a longer followup period and of control groups make confident assessments of the pathogenecity of SIDS deaths or the preventive impact of the intervention program impossible, however. This observation is simply a report that an initial negative expectation did not appear to have been confirmed.

An index of bereavement behavior was administered to all SIDS mothers at each of the three home visits. This index is an additive score based on six questions concerning the degree to which a person has had problems with sadness, loss of appetite, inability to sleep, increased irritability, preoccupation with the lost infant, or an inability to return to normal activities. The index was developed from both Lindemann's and Parkes' work on bereavement and is similar to one reported by Kennell, et al. (1970). The mothers' scores at the first contact were high ($\underline{M}$ = 4.3, $\underline{SD}$ = 1.6), indicating significant mourning and disruption in their lives. The bereavement scores at the second ($\underline{M}$ = 3.1, $\underline{SD}$ = 1.9) and third ($\underline{M}$ = 2.04, $\underline{SD}$ = 1.8) home visits showed a pattern of decline consistent with that reported by others (e.g. Parkes & Brown, 1972). In addition, the majority of subjects (65%) reported few if any such problems by the third visit. Thus, like other bereavement crises, the grieving response to losing a baby to SIDS appears to dissipate in time for most persons. Yauger (Note 2) categorized the pattern of scores over the three visits into those felt to be adaptive (80%) and maladaptive (20%) to the grief crisis. Examples of adaptive patterns would be a high bereavement score at the first visit, a median level score at the second, and a low score at the third or a pattern of high initial scores and low scores at both of the subsequent visits. Yauger felt patterns showing either high or low scores at all three visits or high scores at the first and third visits with a low score at the time of the second visit were maladaptive and likely to be associated with psychological or social disruption later. Although her speculations and classifications need further verification, they do suggest most of the participants in this program had experienced adaptive resolutions to the crises participated by their infants' deaths. Because no control group was available, it is not known to what extent the grief intervention facilitated this process for the participants.

There is a strong anecdotal impression that the families found participation valuable. Many of them had never heard of SIDS and directly expressed gratitude for the information that they were not responsible for their baby's death. In other instances, the visits by the nurse reduced conflicts between family members often centering around inaccurate blaming of the SIDS mothers.

In addition to parents and siblings, the nurses visited other relatives and community workers in their travels around the state. Grandparents and other extended family members were also seen in approximately 66% of the cases, especially when the mother was unmarried and living at home or when they lived nearby. If the family reported difficulties with local governmental officials or professionals, the SIDS nurses also made educational visits to those people as well. In one case, a nurse offered and was scheduled to speak about SIDS to a small and very fundamentalist church group whose members strongly believed a 28-year-old unmarried mother's baby to have been taken by God as a sign to the congregation that the mother had sinned. The nurse never actually made her appearance because the church leadership, after having been provided written information about SIDS, decided that the baby's death was not a sign from God after all and cancelled her visit.

It is the consultant's opinion that the nurses were effective family interviewers and crisis interventionists. They were sensitive to subtleties in communication and mental status and were skilled at gaining others' trust and confidence. The structure provided to the nurses' visits by the program's dual research and service mission and by its educational emphasis seemed to contribute to both their comfort and effectiveness. They reported their work to be rewarding if emotionally draining. The frustration of locating families was the nurses' most common source of job dissatisfaction.

Theoretical Speculations on SIDS as a Unique Crisis

From the collective experience of the nurses' and the author's interviews with SIDS families, it appears that this human crisis shares much with other crises but that it is also unique in important ways. SIDS parents apparently feel the same shock and numbness reported by other victims of tragedy. They also report the kinds of disruptions in eating, sleeping, thinking, and work that are characteristic of depressed persons. Like others reacting to crises, SIDS parents and siblings also appear to be quite open to communication with mental health professionals in the weeks immediately after their loss in that a large proportion of them agreed to participate in home interviews scheduled at their convenience. Their willingness to share their grief with a stranger, like this bereavement behavior, does appear to decline over time. Finally, SIDS parents also report increased rates of religious observation and health injurious behavior, such as smoking and drinking, in the weeks following the deaths.

It is felt that the SIDS crisis is different in important ways as well. Because parents, typically the mother, are often the first to discover their dead infant, the shock produced by the suddenness of their loss appears to be exacerbated. Some parents reported feeling as if they were in a trance state for hours after finding the baby dead. The memory of the discovery often seemed like a dream and denial of the baby's death appeared to persist longer in SIDS parents than is typically reported for other kinds of losses. The primary way in which SIDS deaths differ from other losses is in the extremity of feelings of responsibility that parents report. This responsibility is occasionally projected to another (e.g. physician or relative) but is typically personalized in the form of

guilt. The extreme responsibility appears to grow out of the fact that there is no known cause for the deaths. Although some parents had been told prior to our intervention that SIDS was the cause of death, most were given other explanations. Most of those given correct information admitted still feeling that there must have been something they could have done to prevent the death, perhaps because they had not been given sufficiently detailed information or because they had no opportunities to deal with the guilt feelings that had been aroused in them. SIDS parents seemed highly motivated to seek a rational explanation for the deaths and frequently seized on any available cause (e.g. a new blanket) or scapegoat (e.g. babysitter). That the lack of knowledge among the public and professionals about SIDS adds to the pain parents feel is consistent with the writings of thanotologists such as Becker (1973) and Kubler-Ross (1974) on the role meaning and death anxiety play in human motivation, their basic thesis being that one's fear and denial of their own death motivates their adoption of religious or scientific beliefs that gives an illusion of control over this universal ventuality. The unknown etiology of SIDS deaths can be seen as particularly troublesome for people's needs to believe in causes for human tragedy and thus, simply providing accurate information about SIDS probably contributed more than anything else to the beneficial effect of the grief intervention program. It was as if having an authoritative source tell the parents their baby's death was not their responsibility and that many other infants die from a similarly unknown cause was the major therapeutic and preventive aspect of the program.

Thus, experience with grief intervention following SIDS deaths demonstrated the essential similarity of this crisis with those produced by other kinds of severe loss. It also suggests that the lack of a certain cause for this loss intensified the guilt and other disruptions in living shown by persons in SIDS crises.

Conclusions

The fundamental conclusion of this paper is that mental health crisis intervention techniques can be applied to a geographically scattered and neglected population with significant but neglected mental health needs falling under the aegis of the medical-legal system. Experience with the SIDS counseling program supported our ideas about the importance of certain characteristics being essential to effective crisis intervention, namely actively seeking out families and seeing them early in their crisis states. The majority of persons declining participation in this program were those seen months after the SIDS deaths. Furthermore, it is probably that few of the SIDS families would have sought counseling on their own, since they are undoubtedly similar in this regard to other lower income groups in underutilizing passive-receptive mental health resources. Since effective crisis intervention with this population seems highly possible, it is recommended that mental health agencies expand their services to include active crisis intervention with SIDS families.

Two final conclusions deal with the implications of this program for crisis theory and for preventive programing. Concerning crisis theory, our experience strongly suggests that the importance of rational explanations about poorly

understood phenomena such as SIDS has been underestimated. The intense feelings of guilt and the strong desire for etiological information shown by SIDS family members was their distinguishing feature. Although similar study of families losing infants to any sudden cause may show the age of the lost object to be the main contributor to these feelings, it seems likely that offering rational explanations in any crises where misunderstanding or misinterpretation is possible would beneficially contribute to crisis resolution. Crisis theory and research need to be more cognizant of the utility of simply providing information and creating an atmosphere in which it may be absorbed and understood.

Concerning prevention, the experience with this project provides support for the position that reducing stress and providing additional support during times of accidental crisis is an effective means of primary prevention. Because the SIDS program reduced stress both by alleviating guilt and by providing additional support at a critical time, it is not known what relative mixture of these functions is necessary or ideal. Because it would be difficult if not impossible to design a preventive program systematically separating these elements, research into their relative contribution may need to focus on persons whose prior levels of support and stress are known to vary (e.g. Nuckolls, Cassel, & Kaplan, 1972). The most serious limitation to this conclusion, however, is the absence of control groups and a longer followup interval. Some (Kessler & Albee, 1975) argue that the evidence is thin that primary prevention of psychogenically caused problems is indeed possible. It is felt that preventive programs for persons in grief states like those resulting from SIDS are ideal for research designed to demonstrate a preventive effect. A larger scale program utilizing control groups and unintrusive followup contacts after one to two years is indicated. Such a study would have considerable merit for demonstrating what must currently be viewed as of promising but only of suggestive preventive potential.

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Footnotes

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[1]Persons desiring more information about SIDS can contact the two national parent groups: the National Foundation for Sudden Infant Death, Inc., 1501 Broadway, New York, New York 10036, and the International Guild for Infant Survival, 7501 Liberty Road, Baltimore, Maryland 21207.

[2]A modified version of the program was delivered until Federal funding ceased in June of 1978, but, as little data is available on these families, only the formal study portion of the program is being reported here.

[3]Comparisons made with maternal data on postnatal deaths in North Carolina showed the SIDS mother more likely to be unmarried and to have fewer children.